Orthodox Medicine
Humanistic Medicine
Holistic Health Care

IN THE December 1979 issue the editors of THE WESTERN JOURNAL OF MEDICINE began a forum for dialogue and discussion of orthodox medicine, humanistic medicine and holistic health care. The forum was initiated with statements by persons known to have an interest in and knowledge of this subject. Readers are invited to submit their views constructively and succinctly. As many as space permits will be published in future issues of the journal. At an appropriate time all of the material, published and unpublished, will be collated and, if possible, a distillate will be prepared to summarize the dialogue and discussion.

—MSMW

The Needs and Qualifications of Physicians

ROGER O. EGEBERG, MD

"I AM AFRAID there's nothing more I can do for you." (Said in so many words, or with the raising of the shoulders or the hands or the use of the eyes, to a patient with inoperable cancer.)

"You're not getting any younger, you can expect it at your age." (Said to an older patient with a stiff knee, a painful hip or an aching shoulder.)

"Sure your father is depressed, lots of older people are depressed, I can't do much to make him happier."

These expressions—far, far too common—reveal the attitude of many doctors educated in an era of greatly improved diagnostic procedures and an associated wealth of therapies. Lack of an appropriate treatment, inability to take positive action is something doctors now find it difficult to face. "If I can't cure it with pills, needle or knife, I had better get on to those patients I can cure." How many busy doctors of today would hate to admit that this lurks in their minds?

When I was a boy the doctor came to the home, if necessary, where he looked, felt, listened and sniffed, laid a hand on my head, took my mother by the arm as they walked out of the room, left some medicine, shared the worry, reassured the family and created an aura of hope for improvement. And he or she (yes, our family doctor was a woman) probably returned the next day.

When it was clear that my grandmother was ill with terminal cancer, was when her doctor's work really began. He gave comfort, relief of pain, wholehearted relief of pain, and he gave time, time to answer questions, to explain what he knew, to share the anxiety, the worry and the sadness; time to stroke a brow and to hold a hand.

That is the heritage, still felt, of the horse and buggy doctor. An allopath whose allopathic therapies had so very little to offer. He taught us what they then knew about prevention and encouraged and exhorted us to keep well. Since his time the scientific knowledge of medicine has probably increased tenfold. It has been estimated that it doubled between 1940 and 1960. Our understanding of the cause of disease, the pathology of any disease, our richness of modalities of treatment and our accomplishments in rehabilitation have given us tools, weapons with which to fight our enemy, disease. But this very array of power, resulting in a sense of power to do battle with specific disease states has changed our target, and we have lost our ally, the patient, both ally and battleground.

Perhaps now the doctor sitting at a sick patient's bedside does not touch the patient, does not ask many questions, does not listen very long; perhaps he wonders if he might gain more insight into the illness by going to the library to scan the literature; perhaps he feels that there is not much he can do in the way of prescribing, so why stay. This doctor is really a distant relative of the allopathic physician of the turn of the century. Our allopathic medicine, because of advances in biologic knowledge, has been subdivided into many specialties. Has not medicine itself become with its greater depth a narrower specialty than it was 80 or 90 years ago? Have we not stripped off to a large degree a working concern for the patient's immediate environment, the conditions under which he or she lives? Are we really interested in

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what patients eat and how? Now that it is not a necessary part of living are we suggesting exercise for its own sake and putting that suggestion across? Are we adequately interested in the many facets of the patient's pattern of living that would help to keep him or her healthy? Are we creating in the patient a sense of personal responsibility for achieving and maintaining his potential state of health or well-being? All of this does take more time. It is not easily measured so it is not paid for by Medicare or Medicaid or private health insurance under present methods, and they should carry their share of the blame. The occasional house call, more intelligent listening, the broadening of the field of questioning, the viewing of the patient in a different light—all of these are important to the full care of a patient and they are missed by so very many. These glimpses of the allopath of the turn of the century and the one of the present day—glimpses only, exaggerations possibly, are the central theme of discussions of humanistic medicine and are equally pertinent to the discussion of the practice of medicine by committee which is often implied in the description of holistic health care.

The ideal horse and buggy doctor furnished all that allopathy had to offer and much that it now fails to use or indeed shows interest in. Is that not what we really want back when we speak of humanistic medicine? It is a very important part of treatment, this considering the patient as a person in need of many things, going beyond what medicines or operations can cure. Is that not the core of humanistic medicine no matter how practiced? Many, possibly most, physicians try to fill these needs. If they did not, I dare say there would be a much greater distress about the practice of medicine. Of course, there are those who do not, and be they only 20 percent they would amount to 60,000 physicians in the United States, enough from whom to draw tremendous numbers of horrible examples. Be they 15 percent or 20 percent they are among us. Why? Is it the training or is it the awesome wealth of information, knowledge, in our field or is it the quality of persons chosen to study medicine? Medical schools being as departmentalized as they are, training is certainly part of the cause. Introductions and overviews do not usually carry a feel of the olympian view needed. The wealth of knowledge available certainly plays its role. However, the fundamental change is in the students chosen, the selection process. I do not believe it requires an I.Q. of 135 to 140 to practice good medicine. I do not think that straight A's in chemistry, physics, botany or biology are a prime requisite for a good physician. There is a fallacy in the criteria used for choosing men and women for medical school.

Some decades ago, the federal government wisely decided to support basic biologic research in this country. Looking for a home for such work the government through the National Institutes of Health turned to the medical schools—who were happy to receive the investigators. Increasingly, the government allowed these researchers to teach; at first only 10 percent of their time and later with a more relaxed attitude they passed that decision to the schools. They thus honored research but did not in any commensurate way, that is financially or in professional stature, honor teaching.

With free or virtually free teaching and the prestige and excitement of research the medical schools in a generation were taken over by research. This was certainly to the great good of mankind, but not necessarily so for individual patients. In time, in a couple of decades, the admissions committees were made up of people in the field of research. In their hands, possibly as an easier sifting mechanism, the prime requirements for entry into medical schools—the basic requirements—became grades and aptitudes; grades and aptitudes in science. This focus was possibly born of the hope of getting a brilliant young research associate or a later Nobel laureate. It has been hard on the broader ranging man or woman, less academically brilliant perhaps or less grade motivated, even though such a person's patience and love of individual human beings might stand out like a beacon compared with so many of the 3.7 or 3.8 smooth interview applicants. Those who are chosen, unless indeed they do remain in research, are likely to find practice a bit stultifying, even boring, after 15 or 20 years. They miss out on the reward that would continue to come to one who gets an instinctive satisfaction and joy in helping others. And they become interested to an increasing degree in other pursuits, from motorboats through planes to the building of office buildings.

From personal experience, I would say that the interviews to plumb the breadth and depth of applicants are not worth very much, for the sophisticates put on a consummate and calculated act. As those students, little motivated by the human problems in medicine, progress through medical school, they shed or lose that show of concern that they earlier seemed to have.

The increasing writing and talk—not clamor—about humanistic medicine and holistic health care is nurtured by those many patients who feel a lack of personal concern on the part of physicians. This is real and is based on a felt need. As such a movement gains credibility it attracts a deluge of hocum artists who profess concern for patients as whole persons, who are quick to decry good medicine, who *have* little or no basic knowledge and who display a pseudo-concern, claiming that they are humanistic or holistic. To those hangers-on or shirt-tail riders, I would say you are dangerous to your patients. To the profession I know and belong to I would say let us give thought to the whole spectrum of qualities that we think doctors should have—and let us bring such people into medicine. And to you serious students and practitioners of humanistic medicine I would say I wish you well and thank you for highlighting the unbalanced view of the needs and qualifications of physicians.

Holistic Medicine for Neurosurgeons

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I READ WITH INTEREST the several articles on holistic health care, humanistic medicine and orthodox medicine, and I must say that I am not fully able to grasp the concepts implied.

More specifically, I have been criticized by several persons who are proponents of these dogmas both in my community and in the surrounding communities for my rather naive and, as they state, "inappropriate" approach to diseases of the central nervous system.

We deal with a number of intracranial space-occupying lesions from which, without their removal, a patient would either be dead or seriously impaired neurologically. As an example, I have one case of a 38-year-old man with a 3½-year history of what looks like an infiltrating glioma both on CAT scan and the subsequent angiograms. Needless to say, the standard neurosurgical advice in such a situation would be craniotomy for excision of the lesion.

My critics tell me "that we should not treat the tumor, but should treat the patient." This makes it very unclear to me as to exactly what my role in this patient's care should be. They have strongly advised the patient and his family against operative intervention, and the questions I ask are (1) How can we go about preserving this patient's life and (2) how can we go about alleviating his symptoms and preserve what neurological function is left without a direct attack upon the neoplasm?

There have been some equally vehement criticisms about the methods of dealing with life-threatening head injuries.

It would be helpful indeed if some of the advocates of holistic and/or humanistic medicine would give me guidelines for management of these life-threatening conditions.

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Teaching Medical Students to Stay Healthy

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MUCH OF THE DISCUSSION in the forum on "Orthodox Medicine, Humanistic Medicine and Holistic Health Care" in the January and December issues actually dealt with the widening gap in Medicine between technological treatment of disease and promotion of health. An interesting and important aspect of this division occurs within Medicine: the health status of medical students.

Medical students are like the shoeless sons and daughters of the cobbler—so close to the institutions devoted to the study of health care, yet denying their own mortality, and living a lifestyle which places them at high risk for many diseases. They work exceedingly long hours, eat an abundance of convenience and fast foods, and study under constant stress. As a group, they usually get insufficient sleep and do not have enough time for exercise. This lifestyle is more destructive

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